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Editorial

Dismantling racism in education: In 2020, the year of the nurse & midwife, “it's time.”

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> “Not everything that is faced can be changed, but nothing can be changed until it is faced”.
>
> — James Baldwin (Wilson, 2004, p. 24)

1. The twin plagues of COVID-19 and global racism

Worldwide, seismic upheavals and demonstrations demand the dismantling of structural, individual and ideological racism (henceforth, SIIR). George Floyd's killing by police, numerous other racist murders and unprosecuted ‘deaths in custody’ of Black, Asian and Minority Ethnic/Black, Indigenous, People of Colour (BAME/BIPOC) peoples internationally, have catalysed calls that the underlying racism and oppression enabling such violence to occur with regularity and impunity, cannot continue. #BlackLivesMatter momentum is building and we hope and urge, in this International Year of the Nurse and Midwife, that nursing and midwifery educators respond to this call with insight, honesty and fierce actions that eradicate SIIR from nursing, midwifery and the academy.

The twin plagues of COVID-19 and SIIR have thrown their damaging and dangerous effects into sharpest relief. Maya Angelou was eerily prescient when she wrote:

> “The plague of racism is insidious, entering into our minds as smoothly and quietly and invisibly as floating airborne microbes enter into our bodies to find lifelong purchase in our bloodstreams” (Waite and Nardi, 2019, p.18)

COVID-19 evoked a marked rise in Sinophobic abuse of Asian/Chinese peoples (Chen et al., 2020). In addition, the increased socially determined health risks and greater chances of dying from COVID-19 (Public Health England, 2020a, b) facing BAME/BIPOC peoples, mirror the universally poorer health services and outcomes they have experienced for decades (Ben et al., 2017; Ramaswamy and Kelly, 2015). The evidence is overwhelming (Paradies, 2018; Williams et al., 2019), spanning all age groups, countries, sexes and genders and BAME/BIPOC communities (Grant and Guerin, 2018; Hamed et al., 2020; Likis, 2018; Samari et al., 2018) There is no defensible reason why nursing and midwifery educators should stand on the sidelines and abjure challenging and opposing SIIR a moment longer.

2. “We see you, we hear you”

The history of SIIR in health care and nurse education shows that racism is rarely called out, named, or openly discussed. Nursing and midwifery educators often seem more concerned to preserve a façade of harmony and homogeneity, never to be ‘upset’ by opening the proverbial ‘can of worms’ of SIIR. As Sue (2005) notes however, “Just because the can isn't open, I would ask, does it mean that the worms aren't there?” (Sue, 2005, p. 102). Nurses and midwives have been knowingly, or unwittingly complicit in this silence, maintaining these professions as essentially White institutional spaces (Jeffries, 2020; Mapedzahama et al., 2011). Mostly, this Whiteness is pervasively invisible to White people (Nielsen et al., 2014, p. 193), but never so to BAME/BIPOC colleagues.

We recognise immediately that any mentions of ‘Whiteness’, ‘White privilege’, ‘White guilt’, ‘White fragility’ or even ‘White supremacy’ (Iheduru-Anderson, 2020), are almost guaranteed to induce anger, defensiveness and resistance among many White academics, students and clinicians. The objections to such labelling will be familiar: “I'm not ‘privileged’, I came from a working-class background”, “I wasn't born with a silver spoon in my mouth”, “I've had to work hard for everything I've achieved”, “It's not *my* fault that I was born White”, and more. Every one of these statements may be 100% true. White privilege, however, does not mean you have *not* had a difficult time, it means that the colour of your skin is not a factor that has made it additionally difficult. Small wonder that Sue (2005, p.110) warns of “the Herculean struggle that White folks must exert to overcome their racism, look at themselves honestly, and see the world as it really is”.

Challenges facing the academic community include how to approach and challenge SIIR and how to facilitate dialogues, while avoiding the totalising assumption that *all* White people are inherently and irredeemably racist. If we accept that genuine anti-racism is a

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process of lifelong evolution for many White people and for nursing and academia, how do we encourage and enable that development? Exhortations to simply 'do better', or condemnation when people falter on 'their journey', are almost guaranteed to fail. Students and faculty who want to know more, who want to increase understanding and help dismantle racism, but who won't always 'get it right' and who will sometimes say or do 'the wrong thing', should be part of this change. In education we help undergraduate students develop complex clinical skills and support postgraduate students to navigate difficult research terrains. We do not crush people who 'make mistakes', we help them recognise and understand them and highlight better or more 'correct' ways. This good model is already in place.

Part of the difficulty faced in even naming racism in the academy, is that nursing and midwifery are seen as inherently 'fair' and 'non-judgemental' professions, cloaked in colour-blind pride (Barbee, 1993; Waite and Nardi, 2019). Nurses are great levellers, who treat people equally, regardless of race, culture, gender, income, social status and more. Nurses claim to 'not even notice' skin colour. Perhaps even simulation labs' staff do not notice the likelihood that 94% of simulation body parts are White (Foronda et al., 2017, p. 25). While inclusive, anti-racist care will certainly be true of the practices of many individual nurses, at a profession-wide level, nursing has a long-standing "collective denial and a culture of silence" (Waite and Nardi, 2019, p. 20) in shying away from any racist or discriminatory acknowledgement or discomfort (Barbee, 1993). Midwives appeared similarly reticent about the UK's alarming BAME maternal mortality statistics prior to 2018's MBRRACE report, despite evidence of ethnic maternal health inequalities dating back to the early 1990s (Burnett, 2020).

Perhaps the prime unexamined space is ideological racism; the "tacit network of beliefs and values that encourage and justify discriminatory practices" (Henry and Tator, 2010, p. 55). Such racism cannot be tackled in classrooms by learning more about 'other' cultures, effectively reinforcing racialised stereotypes and perpetuating nursing as colonised care, but by reflecting on unconscious and conscious biases that can blind teaching and learning (Lokugamage, 2019). We must actively dismantle nursing's history of 'transcultural' or 'multicultural' practices, where proficiency is measured by gaining more "ethnocentric knowledge" (Grant and Guerin, 2018, p. 2836). Nursing's practice of abstracting the individual from the context of a racialised society through well-meaning attempts to individualise care (Hilario et al., 2017) must also be critiqued. Prioritising these changes must be championed from the highest levels of nursing and midwifery leadership. If left to individuals, the challenge to call out and dismantle even the smallest racial microaggressions will continue to fall behind the lure of drips, drugs and drains.

Nurses, midwives and the academy can no longer be complicit in the silences around SIIR. Silence is not neutral. Karan and Katz's uncompromising challenge to doctors applies equally to nurses and midwives, when they write that our silence speaks volumes, "It is saying that the death of an innocent black man at the hands of a brutal White police officer is still not enough for you to put your own skin in the game" (Karan and Katz, 2020, p. 1). Let us not maintain the pretence that this is just too difficult an issue for the academic community to tackle. We prepare students to deal with gaping wounds, broken and damaged bodies, profound griefs, disintegrating mental health and much more. We diminish our professions and academic community if we maintain that openly discussing racism, White privilege and ways of dismantling SIIR are 'too confronting'.

3. How SIIR damages and demeans us all

SIIR blights everyone; students, faculty and the academy. Universities in our respective countries are becoming more ethnoculturally diverse, yet the disparity in educational experiences and academic outcomes between White and BAME/BIPOC students remains challenging for higher education. There is a dearth of BAME/BIPOC professors in nursing, midwifery and higher education executive leadership. "If you can't see one, you can't be one", remains a telling disincentive for ambitious BAME/BIPOC nurses. BAME/BIPOC colleagues must become fully integrated into faculty roles, positions in administration and curriculum development, and must become prominent in the professoriate.

The 'degree level attainment gap' between White and BAME/BIPOC students is estimated at around 13%–15% (Brathwaite, 2018; Universities UK and NUS, 2019) with scant evidence that this "is based on some kind of deficit" (Singh, 2011). Academics teaching courses acknowledging and combating racism risk 'punishment' by White students who evaluate such courses poorly (Boatright-Horowitz and Soeung, 2009). In a university, where such evaluations and "neoliberal discourses" (Hilario et al., 2017) are readily accepted, those in power can easily misconstrue faculty capacity to 'keep the customer satisfied', resulting in negative personal and professional consequences. This is despite the weight of evidence showing their racial and gender bias (Drake et al., 2019).

4. Conclusion: how nursing education can begin to overcome SIIR

We must consider decolonising the curriculum (Moncrieffe et al., 2019) so that curricular culture reflects the variety of experiences and backgrounds of students and faculty. A successful, decolonised, all-inclusive curriculum should include four immediate changes:

1. Learning resources must reflect multiple ethnicities to account for differences (e.g., jaundice) and similarities in assessment and diagnosis (Bhala et al., 2020)
2. Higher degree nursing and midwifery researchers should not teach students to merely 'control for race' when health care disparities such as health access are pivotal in the burden of disease (Bhala et al., 2020)
3. 'Race' must be challenged as an unproblematic risk factor for disease in course material. Clearer reflection needs to show the impact of SIIR and subsequent weathering on health status (Sheets et al., 2011).
4. Increase visibility and influence of BAME/BPOC faculty in academia and leadership to continually counter the effects of colonialism and racism (Sheets et al., 2011; Waite and Nardi, 2019).

SIIR operates at the highest level, therefore the call to address racism needs to come from the highest levels in nursing. For example, in Australia, the Federal Government has endorsed a Health Curriculum Framework requiring health professionals to be both clinically and culturally capable The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives embedded this into an Aboriginal and Torres Strait Islander Nursing and Midwifery Health Curriculum Framework (2017). This is an excellent example and resource which recognises that working safely with culture and First Nations peoples are not 'optional extras', but nursing and midwifery 'core business' (https://www.linmen.org.au/wp-content/uploads/2018/08/Nursing-and-Midwifery-Health-Curriculum-Framework_final.pdf, and https://www.google.com/url?q=https://www.linmen.org.au/wp-content/uploads/2018/08/Health-Curriculum-Framework.pdf&sa=D&ust=1593232465108000&usg=AFQjCNGkwngNLSNyPv7Fhfhlxl4zUxHEdw). In the UK, attempts to engender cultural sensitivity through student contact with diverse populations are undermined by ethnically homogenous settings or clinical supervisors' inability to address this learning need. Cultural humility (Smith and Foronda, 2019) is cultivated by diverse faculties and cohorts, and curricula developed alongside BAME/BIPOC students and clients. Regulators should also require the academy to address cultural competence at university level.

To change the curriculum to be inclusive of all peoples, means that we must diversify its authors. Dismantling racism in nursing and

midwifery education is not a singular revolution or transient movement, but a way of life and an ongoing professional obligation for every nurse and midwife. This will be a difficult challenge for each of us in different ways. We will make mistakes and missteps along the way to actualising anti-racism, but *not to try* would be an unthinkable dereliction of what nursing should represent.

A significant achievement for education in this International Year of the Nurse and Midwife would be to bring to life, nursing and midwifery espoused values and principles of equity, fairness and justice, that underpin 'codes of practice' worldwide. Dismantling the SIIR that affects BAME/BIPOC faculty, students and ultimately patients, clients, families and communities would be a lasting contribution to overcoming SIIR that no amount of self-congratulation could equal.

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